Appendix 29
HCFA 1500 Claim Form Instructions For Dental Services

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

If a dentist is providing both CPT and ADA dental procedures, both may be billed on the HCFA 1500 claim form. The only exception to this is that restorative services requiring tooth number and surface information must be billed on the dental claim form.

Wisconsin Medicaid recipients receive a Medicaid identification card upon initial enrollment into Wisconsin Medicaid and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medicaid identification card to complete the patient and insured information.

Element 1 - Program block/claim sort indicator
Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. number
Enter the recipient's 10-digit Medicaid identification number as found on the current Medicaid identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

Element 2 - Patient's name
Enter the recipient's last name, first name, and middle initial as it appears on the current Medicaid identification card.

Element 3 - Patient's birth date, patient's sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medicaid identification card. Specify if male or female with an "X."

Element 4 - Insured's name (not required)

Element 5 - Patient's address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient relationship to insured (not required)

Element 7 - Insured's address (not required)

Element 8 - Patient status (not required)

Element 9 - Other insured's name
Third-party insurance (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing according to Appendix 18a of Part A, the all-provider handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medicaid identification card is blank, the service does not require third party billing according to Appendix 18a of Part A, the all-provider handbook, or the recipient's Medicaid identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medicaid identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A, the all-provider handbook, one of the following codes MUST be indicated in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to:

- Recipient denies coverage or will not cooperate.
- The provider knows the service in question is noncovered by the carrier.
- Insurance failed to respond to initial and follow-up claim.
- Benefits not assignable or cannot get an assignment.
- When "Other Coverage" of the recipient's Medicaid identification card indicates "HMO" or "HMP," one of the following disclaimer codes must be indicated if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation amount.

Element 10 - Is patient's condition related to (not required)

Element 11 - Insured's policy, group, or FECA number

The *first* box of this element is used by Wisconsin Medicaid for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to Wisconsin Medicaid. When the recipient's Medicaid identification card indicates Medicare coverage, but Medicare does not pay, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.

M-6 Recipient not Medicare eligible.

M-7 Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.

M-8 Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medicaid identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for further information regarding the submission of claims for dual entitlees.

Elements 12 and 13 - Authorized person's signature
(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of current illness, injury, or pregnancy (not required)

Element 15 - If patient has had same or similar illness (not required)

Element 16 - Dates patient unable to work in current occupation (not required)

Element 17 - Name of referring physician or other source (not required)

Element 17a - I.D. number of referring physician (not required)

Element 18 - Hospitalization dates related to current services (not required)

Element 19 - Reserved for local use
If an unlisted procedure code is billed, providers must describe the procedure. If element 19 does not provide sufficient space for the procedure description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19. This element may be used for narratives required to exceed limitations.

Element 20 - Outside lab (not required)

Element 21 - Diagnosis or nature of illness or injury
The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 - Medicaid resubmission (not required)

Element 23 - Prior authorization
Enter the seven-digit prior authorization (PA) number from the approved PA request form. Services authorized under multiple PAs must be billed on separate claim forms with their respective PA numbers.

Element 24a - Date(s) of service

Enter the month, day, and year for each procedure when billing for one date of service, enter the date in MM/DD/YY format in the "FROM" field. It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

Element 24b - Place of service

Enter the appropriate Wisconsin Medicaid *single-digit* place of service code for each service. Refer to Appendix 30 of this handbook for Wisconsin Medicaid allowable place of service codes.

Element 24c - Type of service code

Enter the type of service "G."

Element 24d - Procedures, services, or supplies

Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers under the "Modifier" column. The only modifier valid for these CPT procedure codes is "80." If using ADA codes that require tooth modifiers, the tooth numbers or letters must be indicated.

Element 24e - Diagnosis code

When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges

Enter the total charge for each line item.

Element 24g - Days or units

Enter the total number of services billed for each line item.

Element 24h - EPSDT/family planning

HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Enter an "H" for each procedure that was performed as a result of a HealthCheck exam. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG

Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for local use
Enter the eight-digit, Medicaid provider number of the performing provider *for each procedure*, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and, under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this element may cause claim denial.

Element 25 - Federal tax ID number (not required)

Element 26 - Patient's account number
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 - Total charge
Enter the total charges for this claim.

Element 29 - Amount paid
Enter the amount paid by other insurance. If other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of physician or supplier
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 - Name and address of facility where services rendered
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medicaid provider number.

Element 33 - Physician's, supplier's billing name, address, zip code, and phone #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medicaid provider number.